County Options Change Request Form (COCR)

Send this Form to:
Health Check Consultant
Managed Care/Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
Courier #: 56-20-06
Fax: (919) 715-0844

Please Print

County Name/District: _____ Date: _____

Supervisor: _____ Phone #: _____
Signature

DMA Approver: _____ DMA Approval Date: _____

1. Change Health Check Coordinator Information
List the Health Check Coordinator name and phone number as you would like it to appear on AINS letters sent to Health Check eligibles. Enter a change in the mailing address, if applicable.

ADD _____ *DELETE* _____ *CHANGE* _____

Coordinator Name: _____

Agency Name: _____

Address, include currier number: _____

City, State, and Zip: _____

Phone & Fax Number: _____

Email Address: _____

Effective Date: _____

Last Date on Agency Payroll: _____

Leave Without Pay Effective Date: _____

Leave With Pay
Leave time accrued while the individual was otherwise employed by the agency does not transfer for the purpose of Health Check Program reimbursement. If a HCC takes extended leave, DMA will reimburse the agency for the hours of leave accrued while the HCC was employed in the Health Check Project. See Section C of the HC Policy and Procedures for more information.

Leave with Pay Effective Date: _____

How many hours of this leave was accrued while employed as an HCC:

_____

A COCR must be submitted to ADD a Coordinator once s/he has returned to work.

2. Change Supervisor Information

Indicate whether the change is to ADD, DELETE, or CHANGE a name, address, phone number or email:

ADD _____ *DELETE* _____ *CHANGE* _____

Name and/or Title: _____

Address, include currier number: _____

Phone Number: _____

Email Address: _____

Effective Date: _____

3. Change Agency Director Information

Indicate whether the change is to ADD, DELETE, or CHANGE a name, address, phone number or email:

ADD _____ *DELETE* _____ *CHANGE* _____

Name and/or Title: _____

Address, include currier number: _____

Phone Number: _____

Email Address: _____

Effective Date: _____

4. Suppress AINS Letters or Remove Deceased Child.

Please check if appropriate:

Suppress AINS Letters _____ Remove Deceased Child _____

Child's Name: _____

MID #: _____

Reason Given: _____

_____

_____

Adult Making Request: _____